April 26, 2021

Dear Parents/Guardians:

The College Reach-Out Program (CROP) at Florida State University CARE is accepting applications for the Pre-College Summer Academy. This program will offer a **residential camp and day camp for students currently in grades 6 - 11.**

While at camp, students will take academic courses to prepare them for the next academic year and participate in enrichment activities throughout the summer. Students will be connected to FSU staff and mentors that will help them prepare for searching for, applying to, and succeeding in college. At the conclusion of the on-campus component, students will participate in an out-of-town trip where they will tour various colleges and universities, visit historic sites, eat in local restaurants, and participate in a range of cultural activities.

Students must meet both academic and financial qualifications (see below):

**Academic Qualifications:**
Students must either:
1) Be a potential first-generation student (neither parent can have finished a 4-year degree from a college);
2) Have a C or D in English, science, social studies, or math;
3) Have a GPA lower than 2.5 OR;
4) Have an achievement level below a Level 3 in English Language Arts (ELA) and mathematics, on the Florida Standards Assessments (FSA), or on the Algebra I End-of-Course

**Financial Qualifications:**
Parents/guardians must either:
1) Be eligible for free or reduced lunch;
2) Receive public assistance OR;
3) Be placed in foster care

*The summer program and ALL activities are 100% FREE.*

If you are interested in your child participating in the FSU CROP Summer Academy, contact Mrs. Inika Williams at williamsi@fsu.edu or 850-597-6615.

**PLEASE SCAN & EMAIL THE COMPLETED APPLICATION TO WILLIAMSI@FSU.EDU.**

The priority application deadline is Friday, May 21, 2021.

Sincerely,

Mrs. Inika Williams, Ed.S
Upward Bound & College Reach-Out Program Director
Center for Academic Retention & Enhancement (CARE)
Student Name: ______________________

School Name: ______________________

I am applying for the:

____ Residential Middle School Program
   June 20- June 26, 2021

____ Day Program for Middle School
   July 5 – July 9

____ Residential High School Program
   June 27- July 9, 2021
   For rising 11th and 12th graders

____ Day Program for High School
   July 12 - July 23, 2021
   For Rising 9th and 10th graders
Florida State University
2021 Pre-Collegiate Summer Academy

Student Data

Student Name: ___________________________ Birthdate: _______ / _______ / _______

Last Name: ___________________________ First Name: ___________________________ Middle Initial: _______

Mailing Address: ____________________________________________________________

Street Address (where you receive mail)

City, State Zip Code

Home Phone: (____)_________________ Cell Phone: (____)_________________ Email: ______________________

Academic Information

Current Grade: _______ Cumulative GPA: _______

2021-2022 Planned Courses

English: ________________ Math: ________________

Science: ________________ History: ________________

Foreign Language: ________________

Career Interest: ________________

College Choices: ________________

Summer Academy

What type of fitness/wellness activities (i.e. Zumba, Jogging, Volleyball, Basketball, etc.) would you like CROP to provide during the summer program? ________________________________________________________________________

What social activities would you like to see provided during the summer program? ________________________________________________________________________

This summer will consist of many activities that will serve to assist you in your personal, social and academic development. What are some areas that you would like to see this summer? (i.e. self-efficacy, hygiene, math skills) ________________________________________________________________________

Academics, Attendance, Appreciation, Accountability and Attitude

The following essay should be typed, double spaced, Times New Roman 12 font, and contain no less than 300 - 500 words.

• Colleges/Universities, Majors and Careers of interest (explain why choice of colleges and major/career).
• How can the College Reach-Out Program (CROP) assist you in middle school or high school and college success? Also, what contributions can you make to enhance the program?

Student Signature: ___________________________ Date: ___________________________

Parent Signature: ___________________________ Date: ___________________________

Office Use Only:

□ Accepted □ Denied □ Wait Listed Date: _____________ Staff’ Initials: _____________

Center for Academic Retention and Enhancement
109 Collegiate Loop Tallahassee, FL 32306-2139
Phone: (850) 644-9699   Fax: (850) 644-3151   Website: http://care.fsu.edu
# Florida State University 2020-2021 CARE College Reach-Out Program Application

## Parent/Guardian Data

<table>
<thead>
<tr>
<th>Mother's Name:</th>
<th>Father's Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email:</td>
<td>Email:</td>
</tr>
<tr>
<td>Best Contact Number:</td>
<td>Best Contact Number:</td>
</tr>
</tbody>
</table>

Do you live with this parent? ☐ Yes ☐ No

Highest Education Level:
☐ No High School Diploma  ☐ High School Diploma/GED  ☐ Associate’s Degree  ☐ Bachelor’s Degree  ☐ Master’s Degree  ☐ Doctorate/Professional Degree

## Confidential Financial Information

**Required**

Family Annual Income (*before taxes*): $_____  Total # of family members in household (incl. student):_____

Single Parent Household: Yes  or  No

Does your family receive assistance from any of the following sources? ☐ Yes  ☐ No

- _____ Temporary Aid to Needy Families (TANF)
- _____ Social Security
- _____ Food Stamps
- _____ Retirement Benefits
- _____ Veterans Benefits
- _____ Other: ____________
- _____ Free/Reduced lunch

*Attach proof for eligibility verification*

## Parent/Guardian Agreement

I hereby certify that all information provided in this application to the CARE College Reach-Out Program is complete, correct, and true to the best of my knowledge. I understand that the information provided will be used to determine eligibility, is subject to external verification by the Florida Department of Education, and may be released to that entity only for such purposes.

I hereby authorize the school that my child attends to release the following information to FSU CARE staff: a) Report Cards, b) Official Transcripts, c) Test Scores, d) Progress Reports, and e) Behavioral Referral Reports. I also consent for CARE representatives to conduct school visits with my child to monitor their academic progress, and to meet with my child during their non-academic period.

I agree to fully support and encourage my child in his/her efforts to complete high school, attend college, and obtain a college degree. I will also attend meetings and other events as requested by the program and encourage my child to remain active in the program. I also grant permission for FSU CARE to photograph and/or record my child, and hereby release FSU CARE and its partners from any liability by virtue of use of said media.

I hereby consent, declare and represent, as evidenced by my signature below, that I am on notice that Florida State University has no medical, health, or hospitalization insurance to cover my minor child in the event of accident, injury, illness, or death, and hereby specifically release and hold harmless Florida State University, the Florida State University Board of Trustees, the State University System Board of Governors, the Center for Academic Retention and Enhancement, CROP, my students’ school/school district, FSU CARE representatives, FSU/CARE partners, and any and all agents, representatives, and personnel of any of the aforementioned entities and groups from all risks, liabilities, and responsibilities for all accidents, injuries, illnesses, damages, or property losses arising during CROP activities or therefrom. Furthermore, I acknowledge that it has been strongly recommended to me that I obtain health, medical, and/or hospitalization insurance for my minor child prior to participation in CROP. I attest that all information is complete and accurate.

Parent Signature: ___________________________  Date: ___________________________
Use the instructions on this page as a guide to complete the Immunization Form.

**Section 1:**
List any relevant personal and family medical history, and any known allergies, including medications.

**Section 2:**
If you are under 18, this Section is required to be signed by your parent or guardian to allow us to administer medical treatment if necessary.

**Section 3:**
This section should be completed by your healthcare provider’s office. Measles, Mumps, Rubella (MMR) is a required immunization for students born on or after January 1, 1957.

- You must provide proof of two combined MMR (measles (rubeola), mumps, rubella) immunizations.
- The first MMR must have been given on or after January 1, 1968 and on or after the first birthday.
- The second MMR immunization must have been given 28 days or more after the first MMR.

**Section 4:**
This section should be completed by your healthcare provider’s office. Hepatitis B is a recommended but not required immunization. You may choose to opt out of this series by completing Section 6.

**Section 5:**
This section should be completed by your healthcare provider’s office. Meningitis is a recommended but not required immunization. You may choose to opt out of this series by completing Section 6.

**Section 6:**
This is where you may elect to opt out of the Hepatitis B and/or the Meningococcal Meningitis immunization series as referenced in the instructions for Sections 4 and 5 above. Section 6 requires you to mark the box next to the immunization(s) you wish to opt out of and to sign and date. Note that failure to sign and date your decision to opt out of the Hepatitis B and/or Meningitis vaccines will prevent us from processing this form and a hold will remain on your student account.

**Section 7:**
This section should be completed by your healthcare provider’s office if you have received the Meningitis B immunization series. (This is not a required immunization.)

**Section 8:**
This section should be completed by your healthcare provider’s office if you have received the Tetanus-Diphtheria and Pertussis (Tdap) immunization. (This is not a required immunization.)

**Section 9:**
This section should be completed by your healthcare provider’s office if you have received the Tetanus-Diptheria (TD) immunization. (This is not a required immunization unless you are an NCAA Athlete.)

**Section 10:**
This section is the Authorization that the information on the form is accurate. This Section must be completed by your healthcare provider’s office, and must be signed, dated and must have an official office stamp.

**Once completed:** You may submit this form to the Health Compliance Office in one of the following ways:

- **Email:** healthcompliance@fsu.edu Please be aware that email sent over the Internet is not considered secure. FSU shall not be liable for any breach of confidentiality resulting from this form of communication.
- **Fax:** 850-644-8958
- **Mail:** 960 Learning Way, Tallahassee, FL 32306-4178
- **FSU Dropbox:** https://dropbox.fsu.edu
- **In Person:** You may also drop off your forms In Person to the Health Compliance office at UHS during regular business hours [http://uhs.fsu.edu/about/contact-us](http://uhs.fsu.edu/about/contact-us) at 960 Learning Way.

Unless otherwise indicated, University Health Services recommends students receive the optional immunizations listed above. To schedule an appointment, please call 850-644-4567.
### FLORIDA STATE UNIVERSITY

**Immunization Form**

**Part A – Print or type. Illegible form will not be processed**

<table>
<thead>
<tr>
<th>LAST NAME: ___________________________</th>
<th>FIRST NAME: ___________________________</th>
<th>DOB: __________</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLID: _______________________________</td>
<td>EMAIL: ________________________________</td>
<td>PRIMARY PHONE#: __________</td>
</tr>
</tbody>
</table>

#### Please list any relevant personal and family medical history:


#### Do you have any allergies (including Medications): No [ ] Yes [ ] Please list if yes:


#### REQUIRED AUTHORIZATIONS FOR CARE FOR STUDENTS UNDER THE AGE OF 18:

I authorize health center personnel to provide medical and surgical care including examinations, treatment, immunizations and the like for my son/daughter. In the event of serious disease or injury, I understand that all reasonable efforts will be made to contact me but failure to contact will not prevent emergency treatment if necessary to preserve life or health.

Signature: ____________________________ Date: _________________

#### Measles, Mumps, Rubella (Required)

- 2 doses of vaccine OR a blood test showing immunity

<table>
<thead>
<tr>
<th>Dose 1 <strong>/</strong>/__</th>
<th>Dose 2 <strong>/</strong>/__</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM / DD / YR</td>
<td>MM / DD / YR</td>
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</table>

#### *Hepatitis B (Required or Complete Section 6)*

- 3 doses of vaccine OR a blood test showing immunity

<table>
<thead>
<tr>
<th>Dose 1 <strong>/</strong>/__</th>
<th>Dose 2 <strong>/</strong>/__</th>
<th>Dose 3 <strong>/</strong>/__</th>
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<tbody>
<tr>
<td>MM / DD / YR</td>
<td>MM / DD / YR</td>
<td>MM / DD / YR</td>
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</tbody>
</table>

#### *Meningococcal Meningitis Serogroups (Required or Complete Section 6)*

- 1 dose since age 16. (such as Menactra, Mencevax, Menomune, MCV4, Menveo, and ACYW-135)

<table>
<thead>
<tr>
<th>Dose 1 <strong>/</strong>/__</th>
<th>Dose 2 <strong>/</strong>/__</th>
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<td>MM / DD / YR</td>
<td>MM / DD / YR</td>
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#### *Waiver information:* I have received the required information regarding the risk of acquiring Meningococcal Meningitis and Hepatitis B and the benefits of receiving immunizations to reduce those risks. I also understand that I am required to receive these immunizations or to actively decline the immunizations by checking the boxes and signing below. I understand that I may decline either or both immunizations and that declining these vaccines now does not mean I may not receive them in the future.

<table>
<thead>
<tr>
<th>Meningitis Waiver</th>
<th>Hepatitis B Waiver</th>
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</table>

#### Meningitis B (Optional)  Please circle type of vaccine (Bexsero or Trumenba)

<table>
<thead>
<tr>
<th>Meningitis B</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose 1 <strong>/</strong>/__</td>
<td>Dose 2 <strong>/</strong>/__</td>
</tr>
<tr>
<td>MM / DD / YR</td>
<td>MM / DD / YR</td>
</tr>
</tbody>
</table>

#### Tetanus-Diphtheria and Pertussis (Tdap) (Optional) (Required for NCAA Athletes)

Incoming students should have one Tdap booster at 11 years of age or older.

<table>
<thead>
<tr>
<th>Tdap <strong>/</strong>/__</th>
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<td>MM / DD / YR</td>
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#### Tetanus-Diphtheria (Td) (Optional)

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<th>Td <strong>/</strong>/__</th>
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<td>MM / DD / YR</td>
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### This section to be completed by your healthcare provider

**Authorization and additional comments:**

The immunizations dates and any statement of contraindications to immunizations entered on this document are, as of the date signed, verified by my signature below. Additional comments:

______________________________
Clinician OR Records Custodian Name

______________________________
Clinician OR Records Custodian Signature

DATE: _________________
OFFICE STAMP: _________________

Once Completed: You may submit this form to the Health Compliance Office in one of the following ways:

**Email:** healthcompliance@fsu.edu Please be aware that email sent over the Internet is not considered secure. FSU shall not liable for any breach of confidentiality resulting from this form of communication.

**Fax:** 850-644-8958

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**In person:** You may also drop off your forms in person to the Health Compliance office at UHS during regular business hours [http://uhs.fsu.edu/about/contact-us](http://uhs.fsu.edu/about/contact-us) at 960 Learning Way.
Program Event: 2021 Summer Academy

Does your child take any prescription medications that will need to be continued during the CARE Pre-Collegiate Summer Academy?

☐ Yes. If yes, complete PART I
☐ No. If no, complete PART II

PART I (For students taking prescription medications):

If your child takes prescription medications that will be needed during the program, please have your child’s health care practitioner (prescribing doctor) complete PART I and sign. **THIS IS NOT A REQUEST FOR A PHYSICAL EXAM.** Simply ask your practitioner to fill out and sign. Parents should sign in the area noted below as well

**Health Care Practitioner (Doctor) Section Only:**

Prescription Medications: Name of Student (Patient): ___________________________ uses the following prescription medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Purpose</th>
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</table>

Medications available in the program first aid kits (please circle Y for all medications okay to dispense):

Y N Tylenol
Y N Dramamine
Y N Ibuprofen
Y N NyQuil/DayQuil
Y N Tums or other antacid
Y N Benadryl or other antihistamine tablets
Y N Sunscreen 30 SBF or higher
Y N Muscle pain cream (like Icy Hot, etc.)
I, ___________________________ (name of practitioner), have reviewed this patient’s medications and certify that the information is correct and that the patient is physically and emotionally able to self-administer these medications without adult supervision during 2021 Summer Academy. In addition, I have reviewed the list of over-the-counter medications for potential interactions with the patient’s prescription regimen and approve their use when administered by an adult staff member according to package directions.

________________________________________  __________________________  ____________
Signature of Practitioner               Practice Phone    Date

I, ___________________________ (print parent/guardian name) agree that my child can self-administer their own prescription medications as indicated above by the health care practitioner.

________________________________________  ____________
Parent/Guardian Signature   Date

PART II: Over the Counter (first-aid type) medications
(Section for students NOT taking prescription medications).

Parents: Review the list and circle ‘Y’ for yes or ‘N’ for no next to medications that you want or do not want given to your child in case of minor illness or injury.

Y N Tylenol
Y N Dramamine
Y N Ibuprofen
Y N NyQuil/DayQuil
Y N Tums or other antacid
Y N Benadryl or other antihistamine tablets
Y N Sunscreen 30 SBF or higher
Y N Muscle pain cream (like Icy Hot, etc.)

I, ___________________________ (print parent/guardian name) give The Florida State University-CARE/CROP/UB staff permission to administer the items circled “Yes” above while my child participates in The Florida State University-CARE Pre-Collegiate 2021 Summer Academy.

________________________________________  ____________
Parent/Guardian Signature   Date
MEDICATION CONSENT FORM

If your student will be taking prescription medication, please fill out the following information and return it to your Advisor. All medication should be in an original marked container including student name, medication name, and dispensing directions and should be given directly to your advisor prior to departure.

Name of Student _______________________________________________________________

Name of Medication(s) __________________________________________________________

Time of Dose(s) _______________________________________________________________

Any reactions__________________________________________________________________

☐ I give consent for the FSU-CARE Pre-Collegiate Staff to dispense the above medication as directed.

Name of Parent/Guardian___________________________________________________

Date___________________

************************************************************************

NAME OF STUDENT_______________________________________________________

FSU-CARE Pre-Collegiate Programs will supply to students, on an as needed basis only, the following medications: Benadryl, Tylenol, Advil, Pepto-Bismol, Dramamine, & Imodium.

☐ I give consent for the FSU-CARE Pre-Collegiate Staff to dispense the above listed medications as needed.

OR

☐ I do not give consent for the FSU-CARE Pre-Collegiate Staff to dispense any medications.

Name of Parent/Guardian___________________________________________________

Date___________________
Florida State University-CARE  
Pre-Collegiate Programs  
Parental Consent Form

(Print camper’s complete legal name)  (School Student Number)

A. I __________________________________________ approve my child’s participation in
(Parent/Guardian, print your name)

the 2021 Summer Academy affiliated with Florida State University CARE CROP/UB program. I understand that in order for my child to participate in the camp, I must provide a copy of proof of medical insurance to accompany the camp registration form.

Please list any medical conditions and current medications (prescription and non-prescription) that we should be aware of:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

If the program staff determines that a student’s activities while attending the camp are contrary to the general operational, safety and health policies of the University, the parent or guardian agrees to pick up their child from camp.

Emergency Medical Authority

B) In the event that we are unable to contact you, please indicate a secondary contact with authority to initiate medical treatment. Be sure to include a phone number:

______________________________________________________________________________
______________________________________________________________________________

C) In the event that we are unable to contact either you or the emergency contact, I, _______________________________________ authorize the Program Staff to use their
(Parent/Guardian, print your name)
discretion in initiating medical treatment.

______________________________________________________________________________
Parent’s/Guardian’s Signature  Date

______________________________________________________________________________
(Address-Street)

______________________________________________________________________________
(Home Phone) (Other Phone)

Parental Consent  1
Roommate Preference Form

Please list the name of 3 student that you would prefer to room with and the name of 1 alternate student in the event that your first choice is not available. Select two people you would like to have as suitemates. We cannot guarantee that you will be with the roommate of your choice, but we will do our best.

Roommate Choice

1) __________________________________________
   (TOP CHOICE)

2) __________________________________________
   (ALTERNATE)

3) __________________________________________
   (ALTERNATE)

4) __________________________________________
   (ALTERNATE)

Your Name: ______________________________________
NOTICE TO THE MINOR CHILD’S NATURAL GUARDIAN

READ THIS FORM COMPLETELY AND CAREFULLY. YOU ARE AGREEING TO LET YOUR MINOR CHILD ENGAGE IN A POTENTIALLY DANGEROUS ACTIVITY. YOU ARE AGREEING THAT, EVEN IF THE FSU BOARD OF TRUSTEES OR ITS AGENTS (“FSU”) USES REASONABLE CARE IN PROVIDING THIS ACTIVITY, THERE IS A CHANCE YOUR CHILD MAY BE SERIOUSLY INJURED OR KILLED BY PARTICIPATING IN THIS ACTIVITY BECAUSE THERE ARE CERTAIN DANGERS INHERENT IN THE ACTIVITY WHICH CANNOT BE AVOIDED OR ELIMINATED. BY SIGNING THIS FORM YOU ARE GIVING UP YOUR CHILD’S RIGHT AND YOUR RIGHT TO RECOVER FROM FSU IN A LAWSUIT FOR ANY PERSONAL INJURY, INCLUDING DEATH, TO YOUR CHILD OR ANY PROPERTY DAMAGE THAT RESULTS FROM THE RISKS THAT ARE A NATURAL PART OF THE ACTIVITY. YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS FORM, AND FSU HAS THE RIGHT TO REFUSE TO LET YOUR CHILD PARTICIPATE IF YOU DO NOT SIGN THIS FORM.

I. CONSENT FOR PARTICIPATION AND WAIVER OF LIABILITY

I ____________________ (print parent/guardian name), having been fully informed of the CARE Pre-Collegiate Programs’ Summer Academy’s tutorials/activities, hereby voluntarily and freely consent to my child’s participation in the CARE Pre-Collegiate Programs’ Summer Academy. I understand the CARE Pre-Collegiate Programs’ Summer Academy includes my child’s participation in activities including, but not limited to walking, running, swimming, and being transported locally to field trips in and around Tallahassee, as well as other cities in the state of Florida.

In consideration of my child’s participation and for other good and valuable consideration, receipt of which is hereby acknowledged, I, individually and on behalf of my child, expressly assume all risks of injury, accident, property damage and loss arising from or in any way associated with my child’s participation in the CARE Pre-Collegiate Programs’ Summer Academy.

I have actual knowledge, and am fully conscious, of the particular and inherent dangers associated with my child’s transportation to and from the Summer Academy and participation in the CARE Pre-Collegiate Programs’ Summer Academy. Having this knowledge, I, myself and on behalf of my child, hereby and forever, release, waive, discharge, and hold harmless, the CARE Pre-Collegiate Programs’ instructors, coaches, mentors, the
Center for Academic Retention and Enhancement, The Florida State University, the Florida Board of Trustees, and their employees and agents, from any and all suits, liability, claims and/or loss, whether caused by negligence or otherwise, arising from or associated with my child’s participation in the CARE Pre-Collegiate Programs’ Summer Academy. I understand this waiver includes any suits, liability, claims, or demands based on negligence, action, or inaction on the part of the CARE Pre-Collegiate Programs’ instructors, coaches, mentors, the Center for Academic, Retention and Enhancement, The Florida State University, and the Board of Trustees and/or any of their agents or employees.

II.   CONSENT FOR MEDICAL TREATMENT AND WAIVER OF LIABILITY

I hereby declare and represent that I am aware that Tallahassee Memorial Healthcare or The Florida State University Health & Wellness Center will be utilized if necessary for the treatment of certain injuries and illnesses that might arise out of the CARE Pre-Collegiate Programs’ Summer Academy activities. I hereby consent to such treatment. I understand the treatment may involve administration of medication and/or drugs. I do understand that, generally, the administration of proper medication or drugs is preferable to leaving the condition untreated and that violent reaction to the medication or drugs could occur. The following are the drugs or medications that disagree with my child or to which he/she is sensitive or allergic:

(Leaving this space blank means NONE)

Further, my child has the following chronic diseases (e.g., asthma, epilepsy, congenital defects, etc.)

(Leaving this space blank means NONE)

Should routine first aid or medical needs arise such as cuts scrapes, bruises, or lacerations, I consent to treatment necessary to prevent infection and to promote healing (e.g. cleansing and administration of antibiotics) as appropriate under the circumstances.

If a major medical emergency or medical trauma occurs, I understand Tallahassee Memorial Healthcare and/or the Florida State University’s Health & Wellness Center professional staff will provide whatever care or treatment reasonable under the circumstances and will refer my child, as soon as practicable, to the appropriate physician/facility for further treatment. Should Tallahassee Memorial Healthcare and/or the Florida State University’s Health & Wellness Center be unable to contact me, it is my desire my child receive such treatment, nonetheless.

Having full knowledge and appreciation of all risks associated with the medical treatment and referral of my child in case of injury or illness, as set forth in Section II of this document, I, myself and on behalf of my child, hereby and forever, release, waive, discharge, and hold harmless the CARE Pre-Collegiate Programs, the Center for Academic Retention and Enhancement, The Florida State University, the Florida Board of Trustees and their employees and agents, from any and all suits, liability, claims and/or loss, whether caused by negligence or otherwise, arising from or associated with the treatment or referral of my child to the appropriate health care provider. I understand this waiver includes any suits, liability, claims, or demands based on negligence, action, or inaction on the part of the CARE Pre-Collegiate Programs, the Center for Academic Retention and Enhancement, The Florida State University and the Board of Trustees and/or any of their agents or employees.

THEREFORE, I do hereby declare and represent that in making, executing, and tendering this statement of voluntary consent and waiver:

(a) I understand the CARE Pre-Collegiate Programs Summer Academy, the general schedule of activities of the CARE Pre-Collegiate Programs’ Summer Academy, and the dangers and risks inherent in participating in the
CARE Pre-Collegiate Programs’ Summer Academy and its activities,

(b) I have read this statement and understand its contents,

(c) I have had the opportunity to ask any questions I may have regarding my child’s participation in the CARE Pre-Collegiate Programs’ Summer Academy,

(d) I have executed it of my own free will and choice, with the intent to allow my child’s full participation in the CARE Pre-Collegiate Programs Summer Academy and for his/her benefit, and

(e) I am 18 years of age or older and am legally competent to execute this document.

______________________________
Parent Signature			Home Phone Number

______________________________
Work Phone Number  ext.

Emergency Contact Phone Number